



CENTRON SECURITY SERVICES

Daily Security Report

Client No. 2036	Client Name O.H. METALS	Location 10020 SWEET ST UTICA, NY	Date 1/29/87									
Facility Equipment	Detect Clock 1	Weapon No.	Holster 1	Nightstick 1	Raincoat 1	Flashlight 1	Other GATE + TRAILER KEYS					
Officers: Fully explain all items marked "Yes" with time and all detail. For additional space use reverse side and attach incident reports.		Officer—Day Shift (Name) ofc Del Vecchio		Officer—Swing Shift (Name) ofc Kotoszki		Officer—Grave Shift (Name) COATES, EUGENE						
Shift Began 8 AM Ended 4 PM		Shift Began 4 AM Ended 12 PM		Shift Began 12 AM Ended 8 AM		Shift Began 8 AM Ended 4 PM						
Observations or actions taken	Yes	No	Explanation	Yes	No	Explanation	Yes	No	Explanation			
Rounds or stations missed		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
Unlocked doors, gates or windows		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
Unlocked vaults or safes		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
Fire-smoke or hazards		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
1. Extinguishers missing or defective		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
2. Sprinkler system defective		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
3. Fire doors or exits blocked		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
4. Rubbish accumulation		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
5. Motors running		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
6. Lights left burning		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
Injury hazards		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
Visitors	<input checked="" type="checkbox"/>		Blue Box 1 man		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
Trespassing		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
Violation of company rules		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>				
Remarks												
IMPORTANT: If you were ill or injured please explain on the reverse side of this form and call your supervisor before leaving this post.												
1. Were you injured during this tour?	Day Shift Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	1. Yes No	2. Yes No	3. Yes No	Swing Shift Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	1. Yes No	2. Yes No	3. Yes No	Grave Shift Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	1. Yes No	2. Yes No	3. Yes No
2. Did you suffer any illness?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes No	Yes No	Yes No	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes No	Yes No	Yes No	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes No	Yes No	Yes No
3. Have you reported all accidents coming to your attention?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes No	Yes No	Yes No	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes No	Yes No	Yes No	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Yes No	Yes No	Yes No
Signatures	Day Shift 1 Kevin Del Vecchio				Swing Shift 1 Jack Kotoszki				Grave Shift 1 Eugene K Coates			
Signatures	2				2				2.			
Signatures	3				3				3.			

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